Title: Bio-Cultural and Demographic correlates of Women Reproductive Health Behaviour among Pando Tribe of Sarguja District (Chhattisgarh)

INTRODUCTION

Health in the broad sense is one of the most important indicators of development and progress of a community or a nation. “Reproductive health is a state of a complete physical, mental and social well being and not merely an matters relating or infirmity in all matters relating reproductive system and to its function and process.” (ICPD,1994). Reproductive health of women consists of health of the women after puberty, before pregnancy and health care, utilization of health services during pregnancy, delivery care and postnatal care. Life affirming and threatening conditions together makeup reproductive health (Ersheng, 2003).

WHO (1992) has estimated that more than 40 percent of pregnancies in the developing countries results in developing complication, illness or permanent disability for the mother or child. Pregnancy related complications are the leading cause of death for women in all reproductive ages. NFHS -II (1998-99) surveyed in Chhattisgarh and after the study many facts come out about reproductive health of women of Chhattisgarh. The median age at marriage among women age 20-49 in the state is 15.4 which are 34 percent of age group of 15-49. The total fertility rate is about 0.8 children higher in the rural areas of the state than in urban areas. On the basis of BMI, almost half the women in Chhattisgarh (48 percent) are undernourished. The proportion of women under nourished is much higher for women age 20-29 than for older or younger women. Nutrition deficiency is much more prevalent among scheduled tribe women and rural women. In Chhattisgarh 69 percent women have some degree of anemia higher than India (52 percent). 23 percent women are moderately to severely anemic, pregnant women (43 percent) are much more likely than non-

pregnant women (22 percent) to be moderately to severely anemic. Among the 37 percent of currently married women in Chhattisgarh some type of reproductive health problem, including abnormal vaginal discharge, symptoms of urinary tract infection and pain or bleeding associated with intercourse has been reported and 68 percent women have not sought any advice or treatment for RTI.

In Chhattisgarh in three years preceding NFHS-II, only 14 percent of births were delivered in medical facility and only one in three births were assisted by health professional, while 43 percent were assisted by a traditional birth attendant. Mothers of 58 percent of children born in the three years preceding NFHS-II received at least one antenatal check up, compared with 65 percent in India as whole mothers received the recommended number of tetanus toxoid vaccinations for 58 percent of children and received iron and folic acid supplementation for 55 percent of children. In Chhattisgarh only one out of eight births outside a medical facility were followed by a post partum check-up within two months of delivery. Overall, these results show that utilization of health service in Chhattisgarh during pregnancy during delivery and after child birth remains very low. They also paint to the important role of traditional birth attendants for the large majority of births that occur at home. Female sterilization is by far the most popular method, 35 percent of currently married women are sterilized. By contrast, only 3 percent of women report that their husbands are sterilized. Overall, sterilization accounts for 85 percent of total contraceptive use. Use of rates for the pill (1 percent), the IVD (1 percent) and the condom (2 percent) remain very low. The use of these officially - sponsored spacing methods in Chhattisgarh (4 percent) is lower than the use of these methods in India as a whole 7 percent. 2 percent of women were found to use traditional method for family planning. Contraceptive prevalence in Chhattisgarh is considerably higher in urban areas (59

percent) than in rural areas (42 percent), this difference is due to lack of knowledge and awareness in rural areas.

The current focus on reproductive health in India is a result of the global recognition that this health needs have long been neglected and that the consequences of this neglect are divesting, particularly on the lives of women. In order to address the twin goals of population stabilization as well as reproductive health, many countries including India have reoriented their population policy and programme include the reproductive health needs and to provide services that are more responsive and sensitive of the socio-cultural milieu of individuals. The launch of Reproductive and Child health (RCH) programme, by Government of India in 1997, is a step towards integrating various earlier programme of family planning and maternal and child health with those that aim to provide services for the management of sexually transmitted diseases, reproductive tract infection, AIDS, safe and voluntary child bearing and safe abortion. In addition, special attention is being provided to rural and tribal health. In rural and tribal areas unhygienic and unsanitary conditions of living, with virtually no access to basic amenities like safe drinking water and toilets increases the breeding grounds for diseases that endanger the health of its residents, poor housing conditions, poor sanitation, occupational hazards together with inadequately health care system, the tribal people, particularly women continue to suffer with poverty, powerlessness and diseases. In Chhattisgarh 80.02 percent population live in rural areas and 31.8 percent population is tribal population. So realizing the fact, the Chhattisgarh Government revised the state health policy and make a new health policy “The Chhattisgarh State Integrated Health and Population Policy 2006” this policy reiterates the commitment of the state to promote health for all and to provide quality health care services, especially to these in remote and difficult areas. The policy aims at sustainable human development by ensuring that every citizen has adequate access to basic essentials of life, reducing

socio-economic disparities, improving the quality of life and stabilizing the population. Securing the rights of disadvantaged and marginalized groups would be given highest priority. Improving reproductive and child health services and women's empowerment and would be one of the cornerstones of this policy.

AIMS AND OBJECTIVES

There is lack of information about reproductive health status of women among tribal population of Chhattisgarh especially among the woman of Pando tribe which is under consideration for the status of "Primitive tribe". Therefore, realizing its importance and to fill this lacuna the present study will be undertaken with the following aims and objectives:

1. To study the Reproductive Health behavior of adolescent girls and women of Pando tribe.
2. To assess the magnitude of reproductive morbidity before and after pregnancy and maternal and child mortality during pregnancy and delivery practice.
3. To assess the nutritional and health status of Pando adolescent girls and women by hematological
4. test (Hb) and anthropometric measurements (BMI) and to examine bio-cultural determinants of it.
5. To analyze the transgenerational changes for reproductive health behavior and health practices of child and mother.
6. To analyze the bio and socio-cultural determinants of reproductive health status and reproductive rights of Pando adolescent girls and women.
7. On the basis of findings give some suggestions for improving reproductive health status of Pando adolescent girls and women, which will help to improve models of Health Plan of State Government.

Review of Literature

About one third of the total diseases burden among women aged 15-44 years in the developing countries is linked to health problems arising out of pregnancy, childbirth abortion and reproductive tract infections (World Bank, 1993).World Bank (1994) has stressed on seven minimum parameter for the reproductive and child health care study, viz. prevention and management of unwanted pregnancies, prevention and management of reproductive tract infections and sexually transmitted diseases, child survival, maternity care, safe abortion, reproductive health for adolescents and effective referral systems. The study of reproductive behavior of Indian women was started by Sen in 1953, in which she attempted to evaluate the geographical effects on fertility. Few hospital based study (Melrose, 1984) and community based study (Gortmaker, 1979;Bhatia, 1993) Show that failure to seek ante-natal care services increases the risk of pregnancy outcome. Shariff (1990) has described pregnancy as a state in which a woman is regarded as not in normal or good health. Bhatia's (1993) study in India, has reported that 78 percent of maternal deaths can be avoided by specific timely actions. Evidences from studies suggest that women who receive antenatal care experience the lower rate of maternal mortality (Huque et al, 1991). Study on Mumbai (Aras et al, 1996) Showed how early registration of pregnancy increases the maternal weight gain reduces the risk of low birth weight baby. Nutritional and dietary pattern of pregnant women is a major factor which controls mother's health status and pregnancy outcome.. Hasan (1979) has argued that for the people living in Indian villages, beliefs, values, customs and practices related with the phenomena of food, health and disease are more important than health itself. Voluminous review of literature on 222 different cultural communities by Mead and Newton (1967) suggested that every society has prescribed beliefs, customs and norms regarding behavior during pregnancy, labour (delivery) and post partum care. All these beliefs are related to food consumption physical activities,

health care and family planning during this particular period. In this respect, individual, family and society plays separate roles to manipulate health-seeking behaviour of the pregnant women. Mehta (1992) has stated that family has an important responsibility over matters concerning maternal and child health. Preventing socio-cultural attitudes and practices head to very poor health status of women. Further, familial and societal constraints on women's access to health services, gender relations, patterns of socialization and the resultant sexual behaviour. Krishnan 1975, Cleland and Van Ginneken, 1988, reveled that expose women unfairly to reproductive tract infections, which in turn pose serious consequences for reproductive health well being and surviving. Many studies have shown that education is an important determinant for the reproductive and child health care. Culture and the traditions also play a vital role in the maternal and child health care practices and behaviour. (Sigerist, 1977, Polgar, 1662; Landy, 1977; Brownlee, 1978; Marmot, 1981; Janes, 1986. Agrawal et al. (1987) covered all the socio-demographic problems in India in his population problem report. Gender based power relationships of men and women has been recognizes as an important facet of reproductive health behaviour of women (Gupta and Weiss, 1993) increased efforts are being made by research as to understand the power dynamics into service delivery, education and research. Power in sexual relations refers to relative ability of one partner to act independently to dominate decision-making, to encourage in behaviour against the other partner's wishes or to control a partner action (Pulerwitz et al, 2000).

The study conducted by Das &Shah, 2003 reveled that deaths and illness from reproductive causes, are high amount the highest among poor women the world over and particularly among women in developing countries).

Noteworthy Contribution

Reproductive health of women consists of health of the women after puberty, before pregnancy and health care, utilization of health services during pregnancy, delivery care and postnatal care. Caste religious and cultural activities, illiteracy and poor economic conditions, somehow or other influence the people in obtaining and utilization of the health services. "International conference on Population and Development" (ICPD) held at Cario, Egypt has promoted the formulation reproductive policies and programmes. This conference has been hailed as victory for the cause of women. In India the Bhore (1946) committee, even before independence, gave importance to reduce maternal and infant mortality with emphasis on maternal and child health. India was the first country in the world to have started the National family planning programme (NFPP), in 1952, as a purely demographic programme. The national health policy of 1983 documented the required attention to maternal and child health (MCH) in detail. Subsequently, the child survival and safe motherhood (CSSM, 1990) programme, supported by UNICEF, was adopted during 1992-93. Based on the recommendations of National Population Policy (NPP) in 1994, target approach was with drawn from the entire country by April 1996. After receiving the global acknowledgement of reproductive health concept in Cairo conference 1994, Government of India launched reproductive and child health (RCH) programme in September 1997. In 1999. The Tenth five year plan (2002-2007) emphasizes a monitor able target of reduction of IMR to 45 per 1000 live births by 2007 and 28 per 1000 live births by 2007 and 28 per 1000 by 2012. Priority has been set on reduction of maternal mortality rate (MMR) ratio to 200 per 1, 00,000 live births by 2007 and 100 per 1,00,000 live births by 2012.

The Eleventh Five Year Plane (2007-2012) pay attention for following areas of reproductive and child health:

Reducing infant mortality rate.

Reducing maternal mortality rate.

Reducing Malnutrition among children achieving 100 percent civil registration of births.

Complete abolition of female feticide, female infanticide and child marriage and ensuring the survival, development and protection of the girl child.

Improving water and sanitation coverage both in rural and urban areas.

In 1991, Winnard has raised his voice for negligent attitude towards 'Pregnancy is special', which is a major challenge for safe motherhood programme. Becoming a mother at early ages has a profound affect on the health of mother and the child and it has high level of acceptance in Indian society. The first two National family health surveys viz. NFHS-1, 1992-93, (IIPS, 1994) and NFHS-2, 1998-99, (IIPS, 2000) reveals that the median age at first birth has come down from 18.8 years in 1992-93 to 17.7 years in 1998-99. It also show that short birth intervals (less than 24 months) and 4th and higher birth orders, mostly prevalent among scheduled caste and schedule tribe populations, which has adverse effect on mothers health. Kost et al., (1998) have found that unplanned pregnancy is the only factor that contributor to unhealthy pregnancy is the only factor that contributes to unhealthy pregnancy behaviour. Their study suggests a need for attention on social and demographic factors that contribute to late recognition of pregnancy and delay entry into antenatal care. Pandey G. D., J. Roy and R. S. Tiwari (1997), studied on the socio-cultural aspects of health care in Pando tribes of M. P. The study emphasized improving MCH and family planning acceptability in the tribe and to take suitable measures in light of their socio-cultural practices to improve infant mortality level and other health indices.

Recently, Pandey et al; (1998) while analyzing the NFHS-I data considered child's year of birth, child's sex. Mother's age at child birth, residence, mother's literacy, religion, caste or tribe membership, mother's exposure to mass media, availability of toilet facility, type of cooking fuel as the covariates of infant mortality and reproductive ill health.

National population policy (2000) has set a goal to safe motherhood and empowering women for improving health and nutrition. Special attention have been made for most vulnerable groups population like scheduled caste, tribe segment and specifically on scheduled tribal population.

In recent about domestic violence in India. NFHS-II (1998-99) found that in Chhattisgarh there is widespread acceptance among ever-married women that the beating of wives by husband in justified under some circumstances. Almost two-third of ever-married women (62 percent) accepts at least one of six reasons as a justification for a husband beating his wife. 17 percent of ever-married women in Chhattisgarh have experienced beating or physical mistreatment since age 15, and 9 percent experienced such violence in the 12 months.

AREA AND PEOPLE

The Pando tribe is grouped with Bharia- Bhumia or Bhuihar- Bhumia in the list of Scheduled tribes. The tribe is under consideration for the status of "Primitive tribe". They are socially and economically backward and have poor health status .In newly formed Chhattisgarh state they are concentrated in Surguja, Koriya and joining areas of Bilaspur district. After partition from Madhya Pradesh the Chhattisgarh Government established "Pando Development Agency" at Surajpur block in Surguja district to pay special attention for welfare of Pando tribe. In census of Pando tribe clubbed with Bharia-Bhumia but the separate population of Pando tribe is estimated by

Pando Development Agency. The population detail in Sarguja and other information are given in the table:

Population under study (Pando tribe)

Census	Population			Distribution	Language Family	Occupation
	Male	Female	Total	Sarguja, Koriya Bilaspur	Indo-Aryan	Hunting & gathering, agricultural labour
2001*	16,540	15,276	31,816			
2007*	12,622	14,324	26,946			

*(According to Pando Development Agency, Surajpur)

Methodology

Research Design

The proposed study will be based on material collected through community based field investigations of approximately 250 samples including adolescent girl (10-19 years) and women (20-35 years and above) of Pando tribe from Surajpur and Lakhanpur of Sarguja district of Chhattisgarh. The village will be selected by purposive sampling method that will be based on easy approachability to the village as well as concentration/density of the targeted group.

Parameters

The following parameters will be looked into the proposed investigation:

1. Socio-cultural and Demography

Socio-cultural profile of the family of adolescents girls and women, structure and size of family, fertility and mortality and its determinants, gynecological and obstetric morbidity, health care practices, reproductive rights and constrains in decision making of adolescent girls and women regarding Reproductive health etc.

2. Biological

ABO and Rh blood group incompatibility and fetal wastage, BMI and Hb level and pregnancy outcome.

Techniques

Following techniques will be adopted to collect the data: The interview-cum-schedule method. Observation methods will be used to collect data of socio-cultural and demographic profile of household of girls and women.In depth interview, life cycle analysis and genealogical methods will be used to collect data on dimensions of reproductive health behavior. Group discussion method will be employed (where necessary) to validate the data. In addition, serological (ABO and Rh blood group) of families and anthropometric investigations and Hb test of women will be collected as per method suggested by Weiner and Lourie (1969).

Expected Outcome

Above brief review underscore the fact that the information on Reproductive Health issues among tribes is inadequate and particularly in Chhattisgarh no study is available. The great value of the proposed study lies in focusing attention on complex problems of nation and international importance viz. adolescent and women Reprouctive Health and relates bio-cultural dimensions. Thus, the present study is directly concerned to achieve the visionary goals of ARH and RCH Policy, NPP (National Population Policy) and NHP (National Health Policy).

Reproductive health studies of Pando tribe deserve much attention due to the tribe is under consideration for the status of “Primitive Tribe” by the Government of Chhattisgarh. The expected

outcome of the proposed in-depth study with a holistic view on Pando tribe would play vital role to unrevealed and determines of reproductive health issues in Pando tribes of Chhattisgarh. The finding of proposed study would provide valuable insights not only to the academicians for the future study also to policy makers and planners for planning and strengthening health care programmes to achieve the visionary national socio-demographic and health goals.

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Hypotheses

This study has following hypotheses -

1. Frequent Early age at marriage is greatly correlated with early exposure to pregnancy and more number of children among Pando adolescent girls and women.

2. Health seeking behavior, nutritional status of pregnant and lactating Pando adolescent girls and women, reproductive morbidity and treatment seeking behavior are closely associated with beliefs and taboos.

3. In studied areas unhygenienic and unsanitary life style, lack of basic amenities is adversely affecting the heath status of Pando adolescent girls and women.

4. Social bounding as well as lack of awareness and illiteracy of Pando adolescent girls and women leads to more child bearing and poor health status**.**

5. Low income and large family size of household lead to malnutrition among Pando adolescent girls and women.

6. Among Pando adolescent girls and women. Utilization of health care services during pregnancy, during delivery and after child birth remains very low.

Tentative chapterasation of thesis

The thesis will organized in following headings:

Chapter 1: Introduction

Chapter 2: Area and people

Chapter 3: Research Design and Methods

Chapter 4: Socio-cultural and Demographic Profile of Studied Population

Chapter 5: Reproductive Health Profile of Pando Adolescent Girls and Women

Chapter 6: Socio-Cultural Determinants of Reproductive Health

Chapter 7: Health and Nutritional Status of Adolescent Girls and Women

Chapter 8: Reproductive Right and Women Empowerment

Chapter 9: Summary, Conclusions & Suggestions

References

Appendix

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